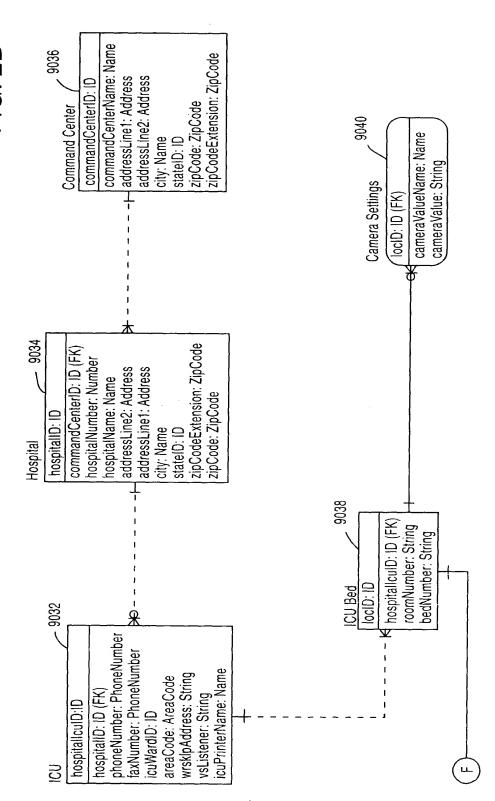
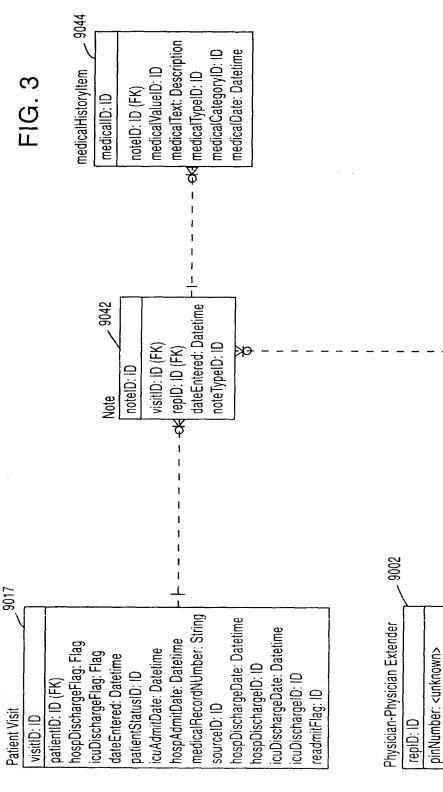




FIG. 2B







lastName: PersonName firstName: PersonName

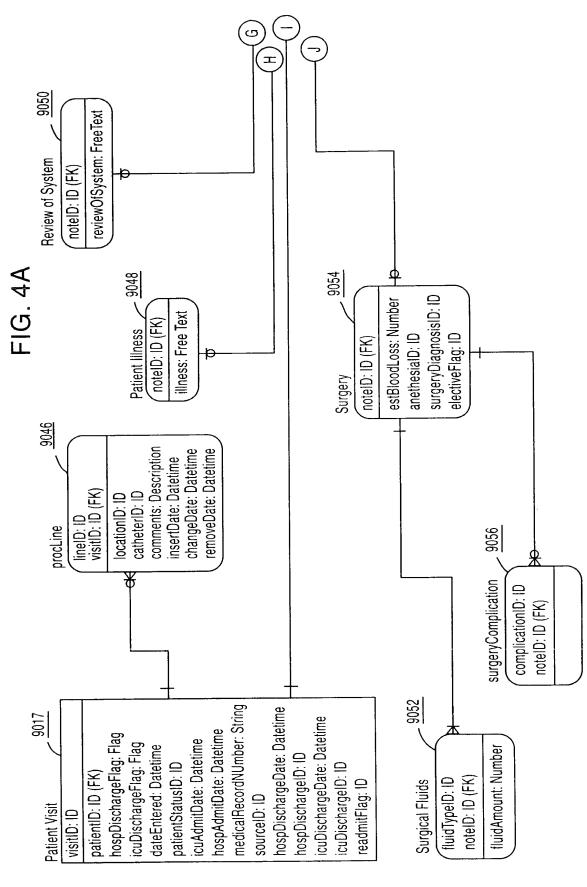
physicianUPIN: String

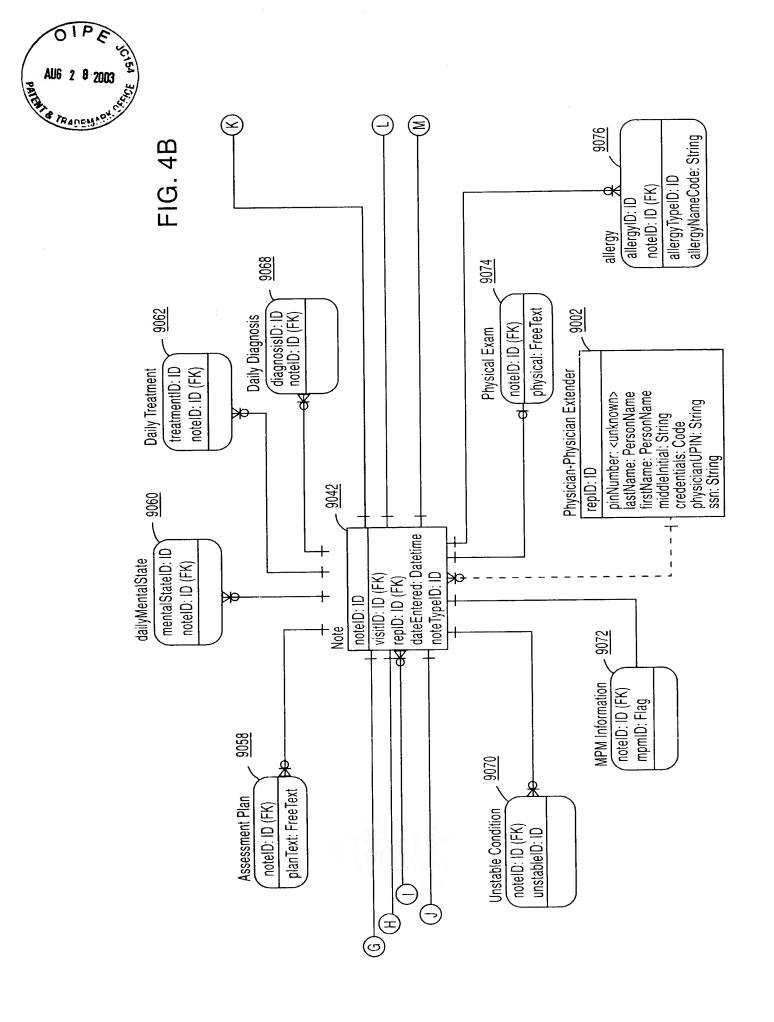
ssn: String

middleinitial: String

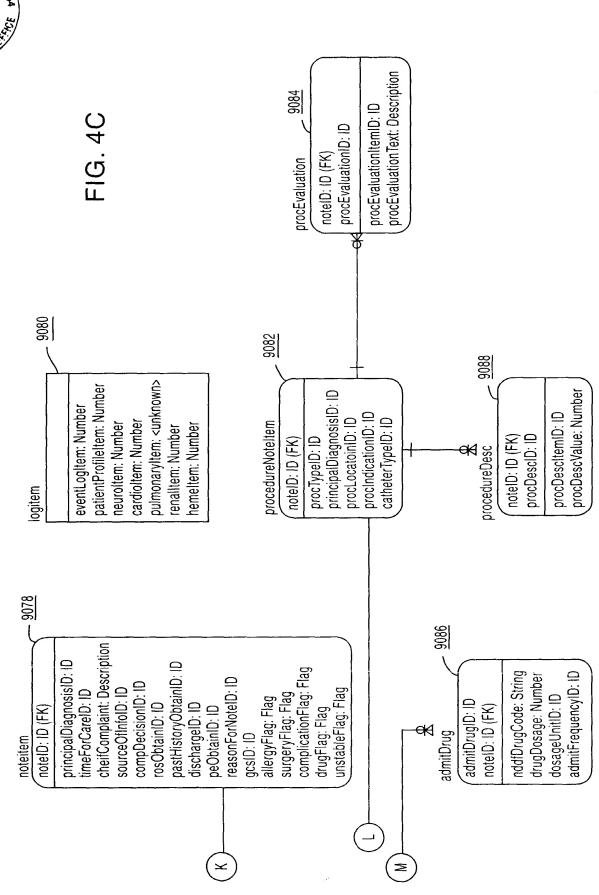
credentials: Code



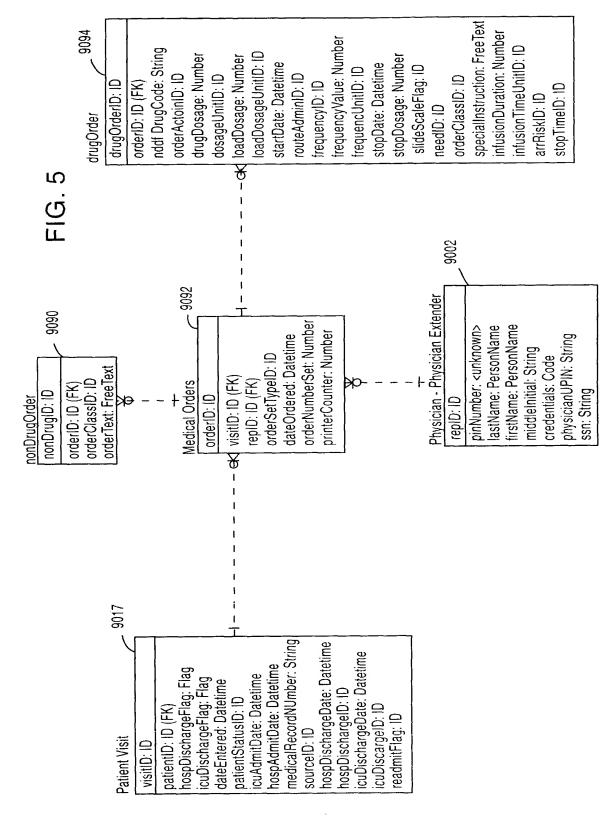


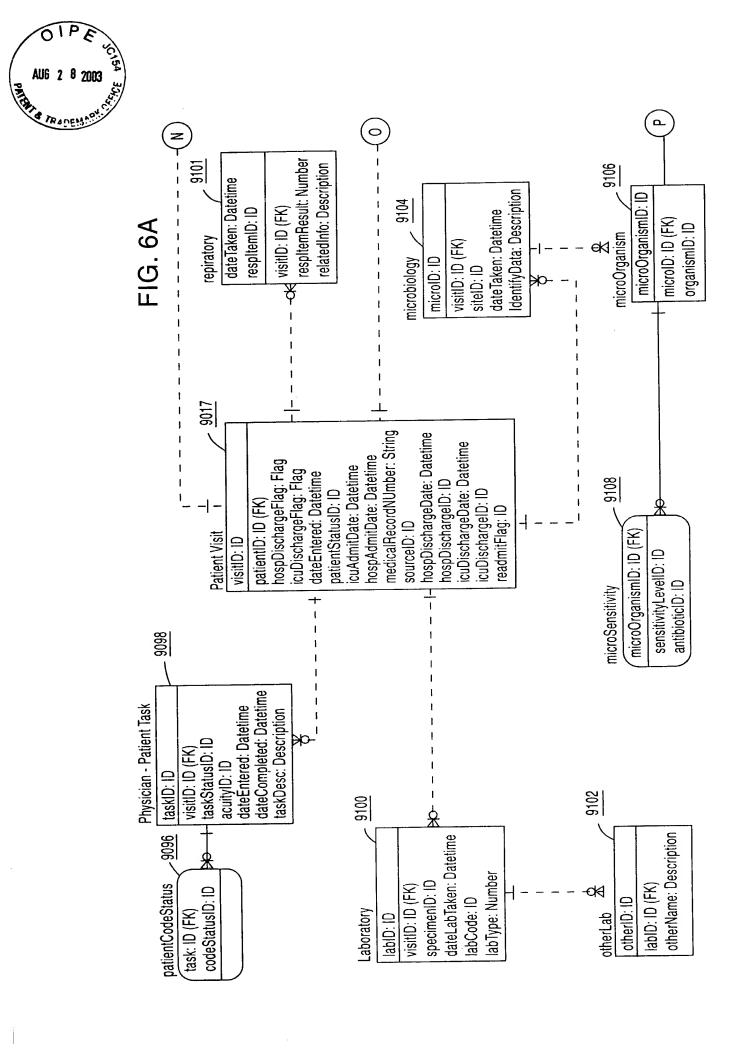














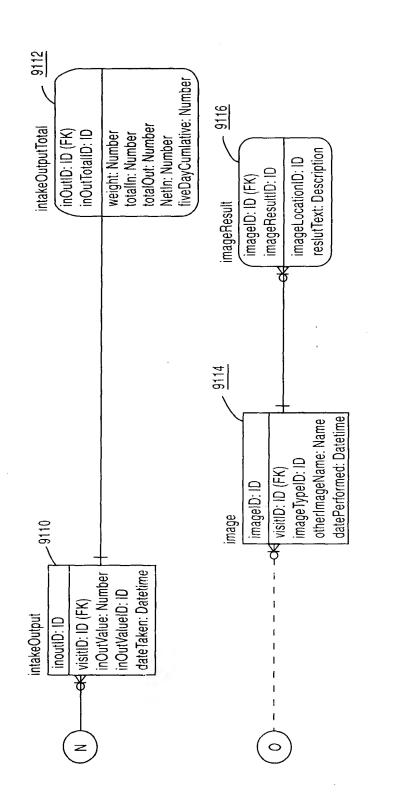
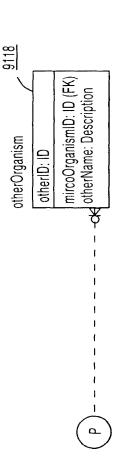
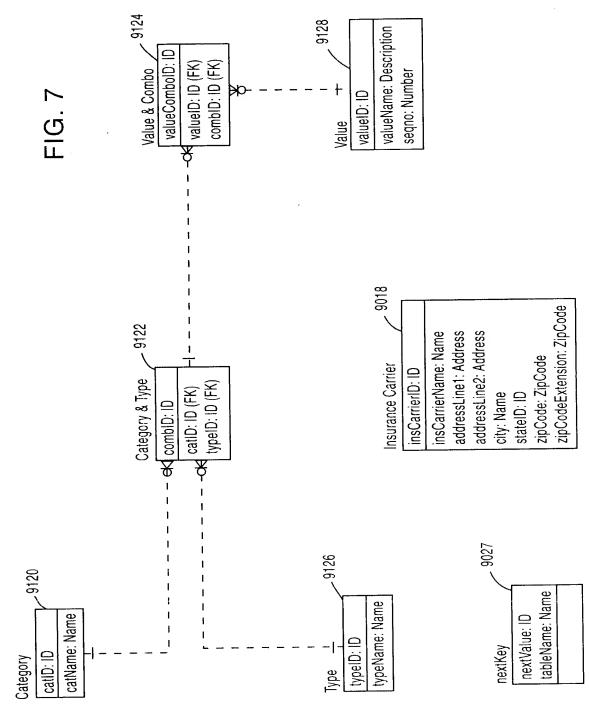


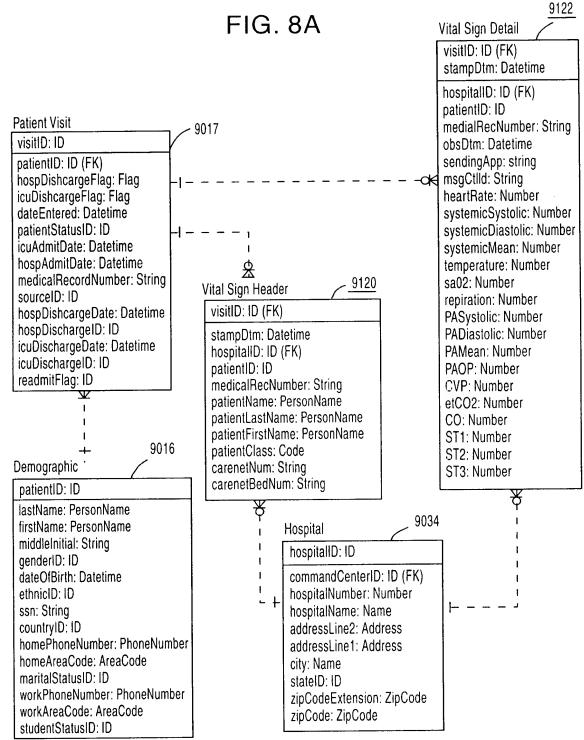
FIG. 6B



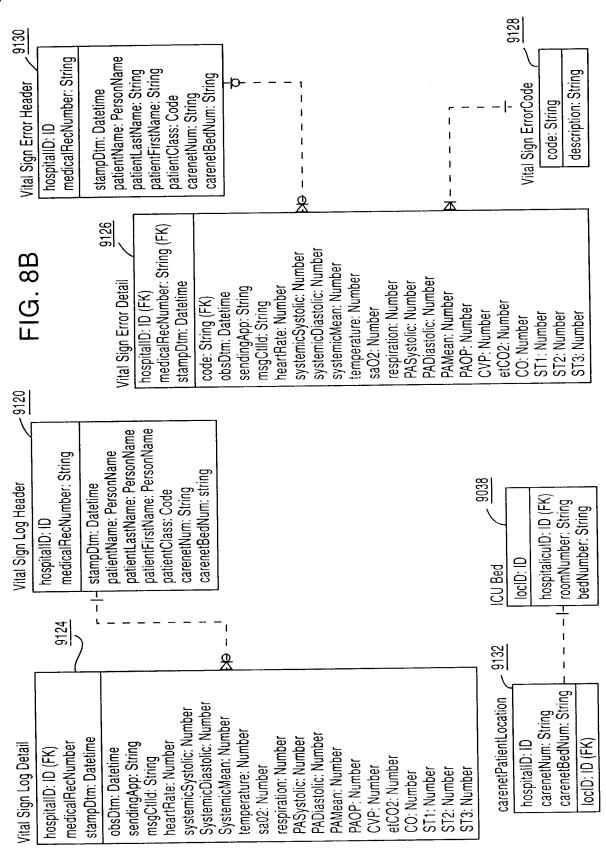




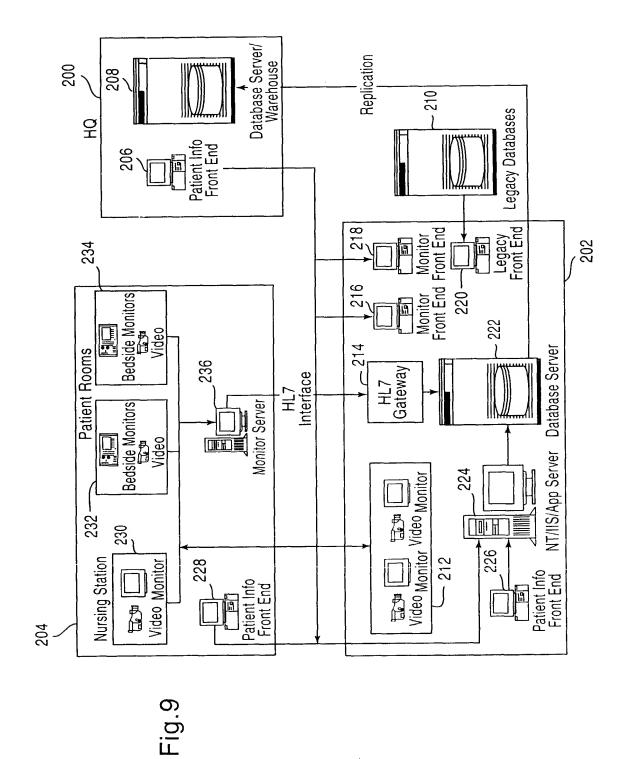




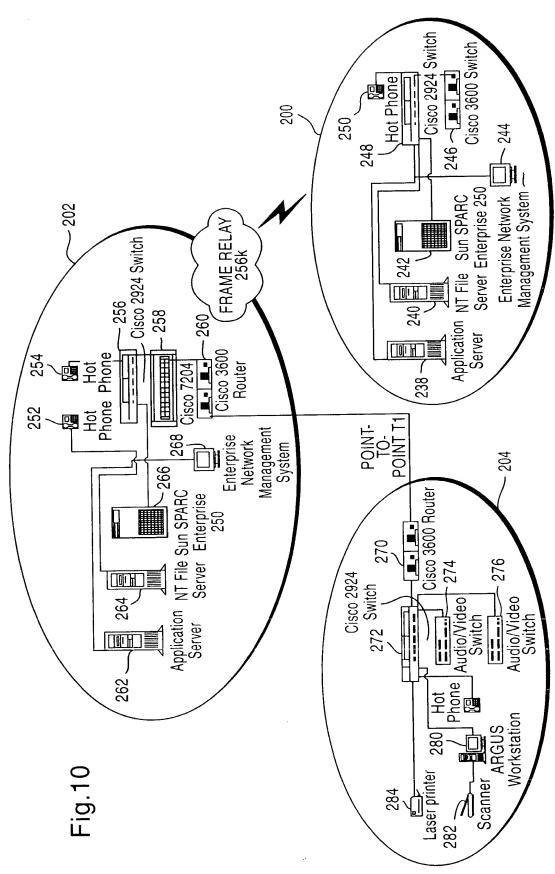














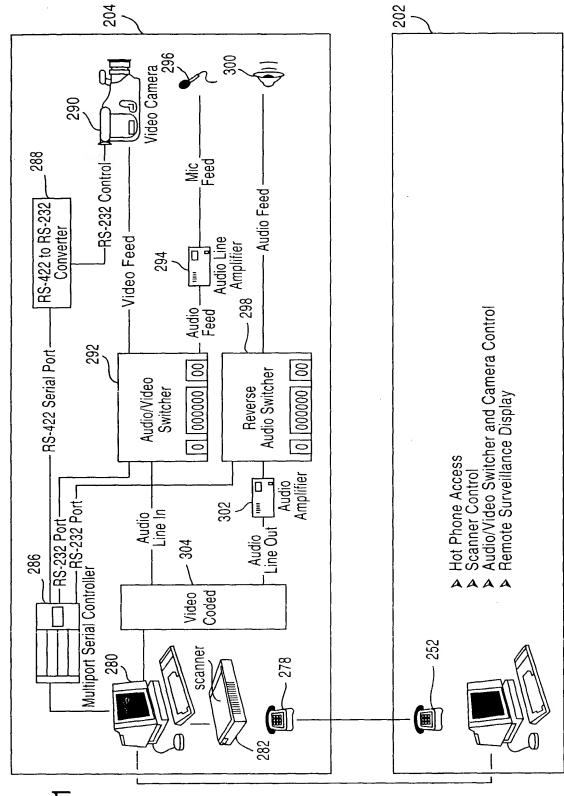
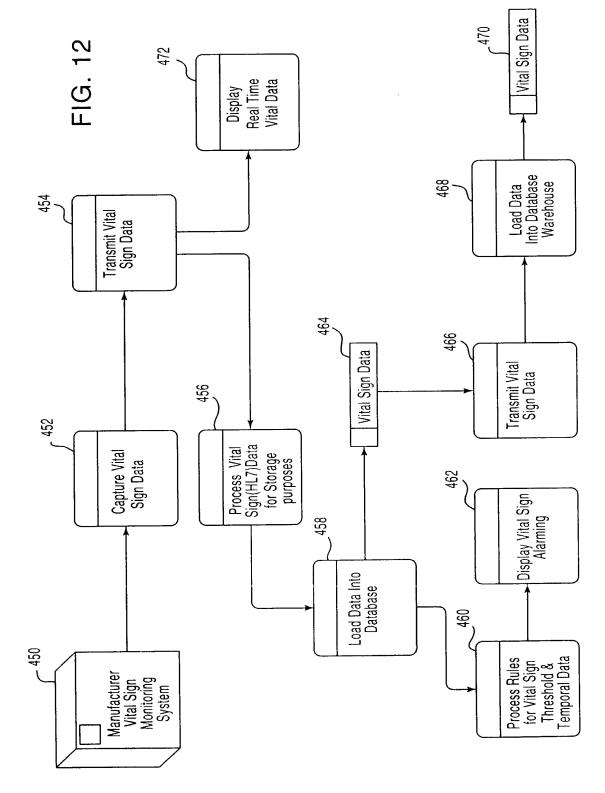
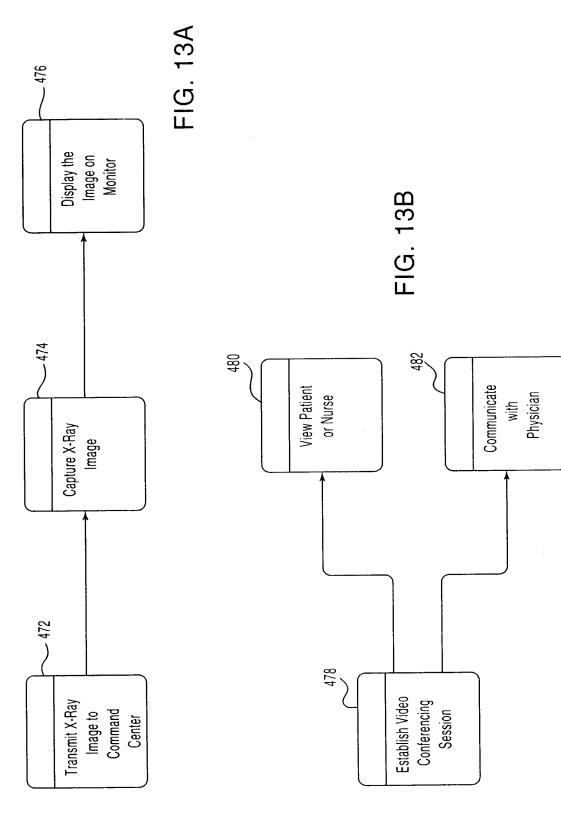


Fig.11

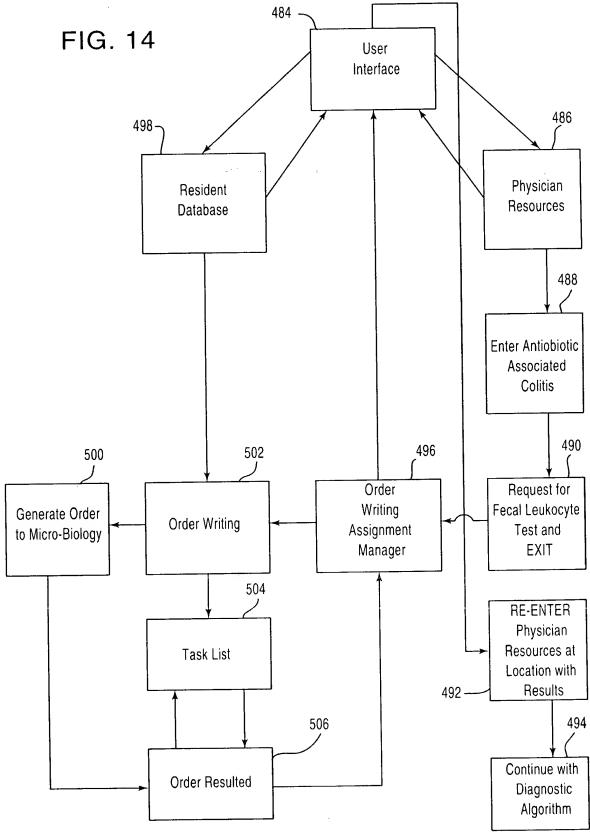


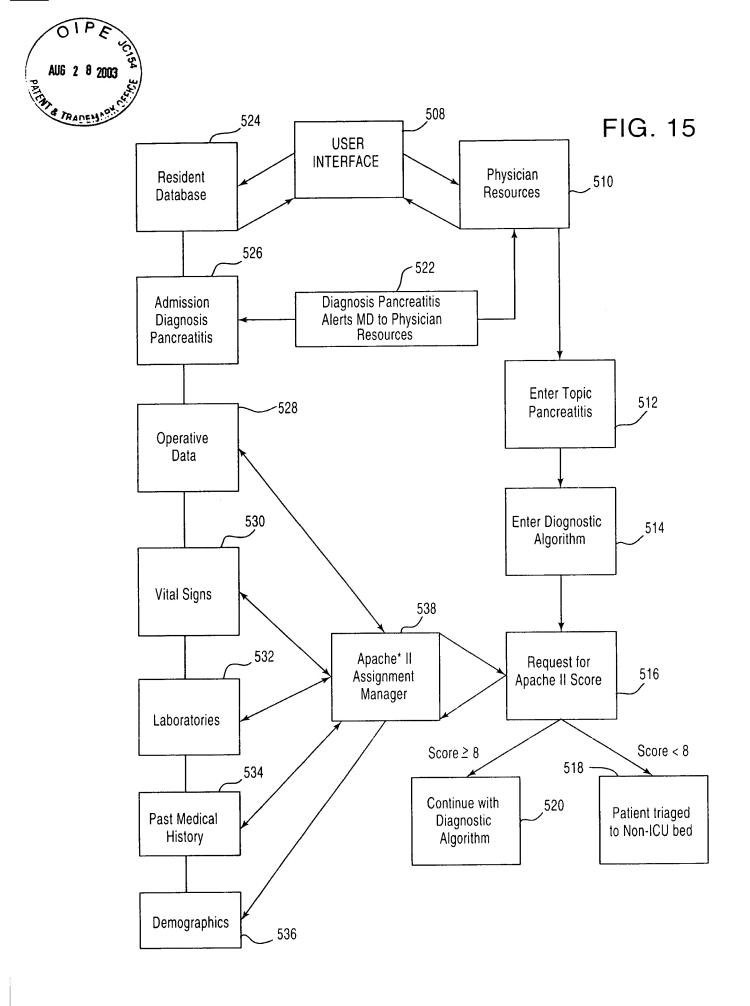




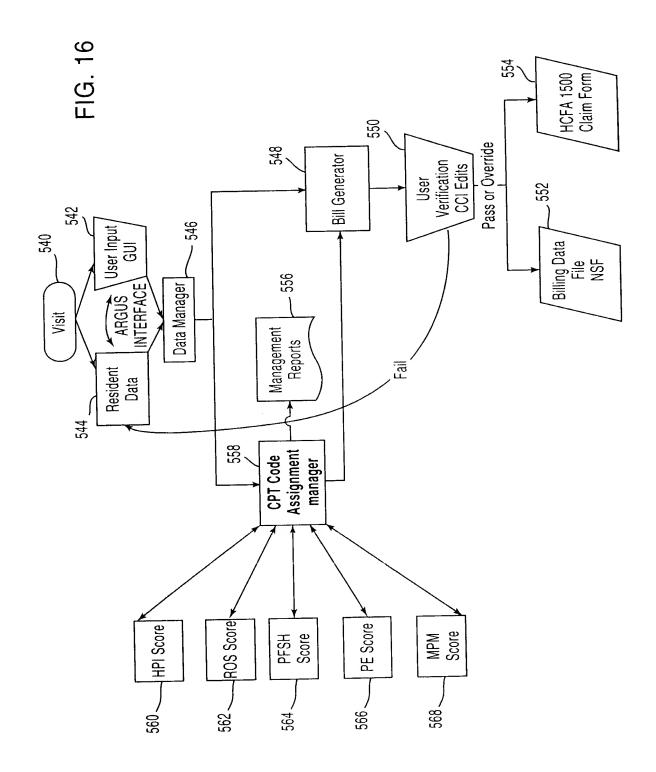




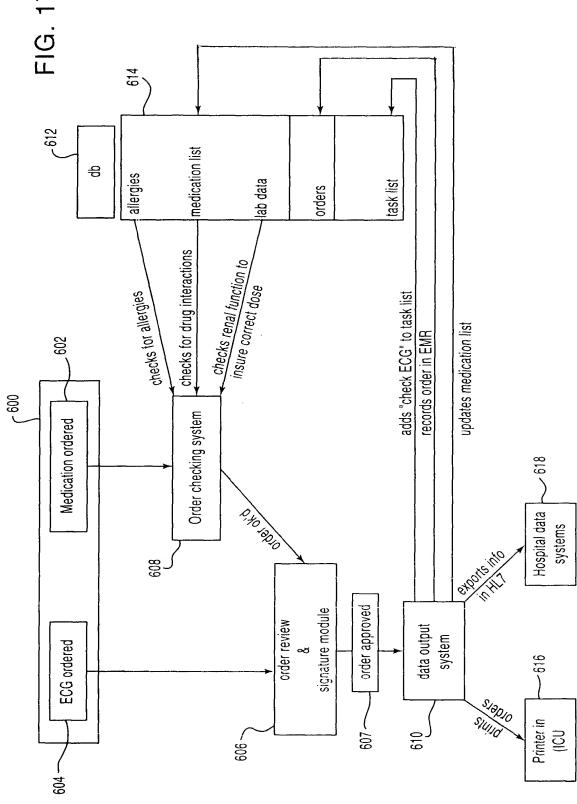














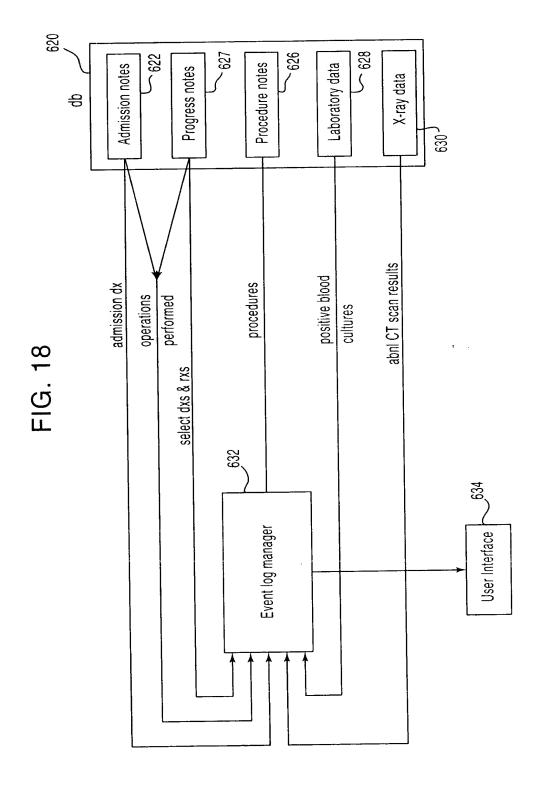
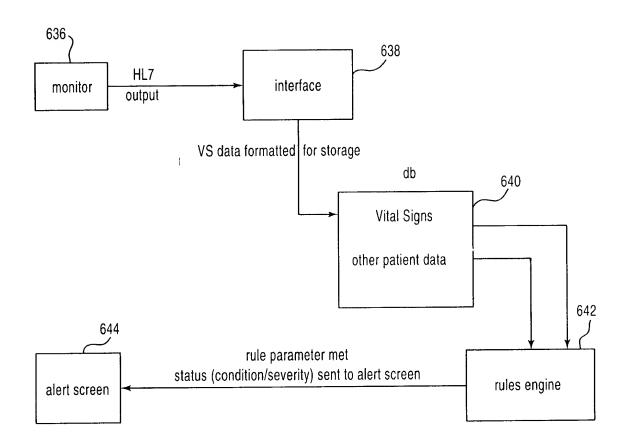
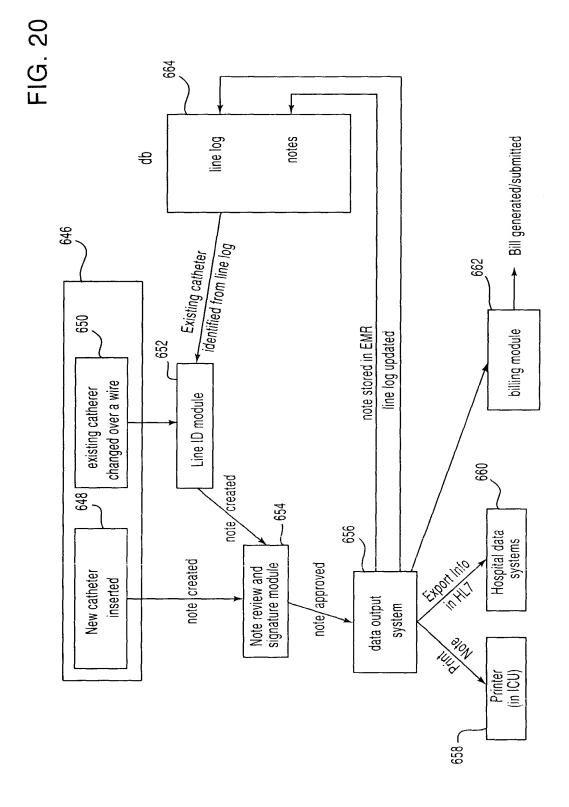


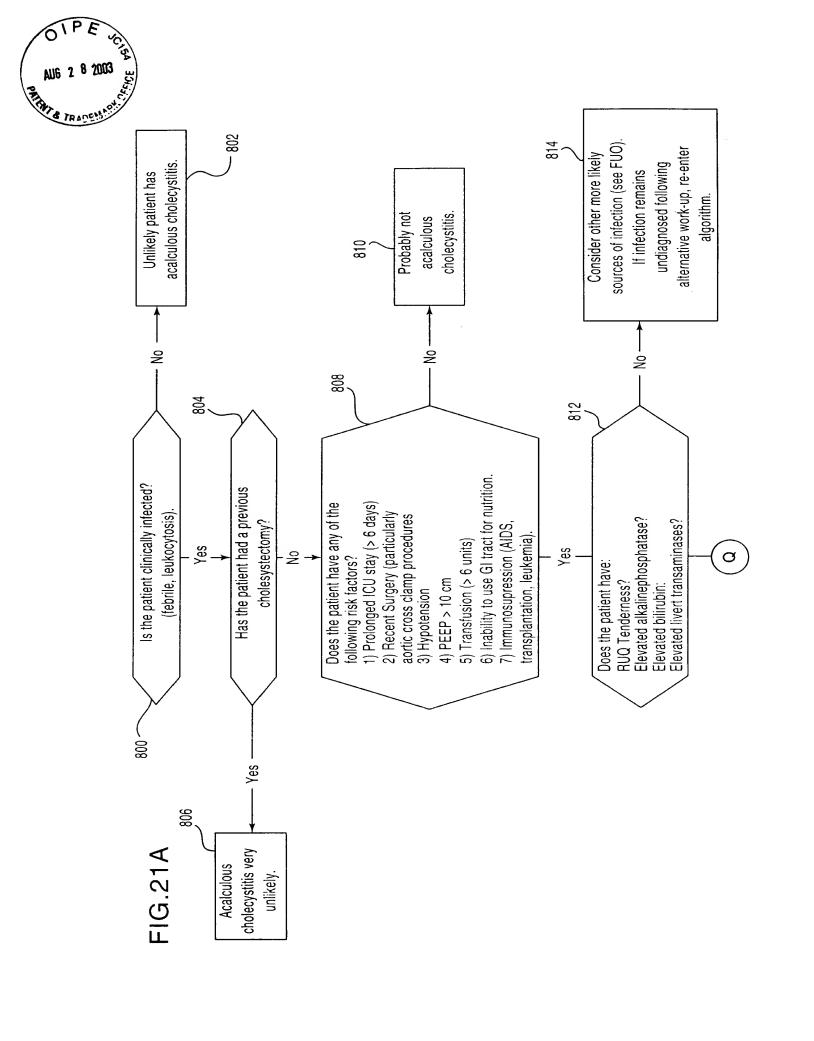


FIG. 19









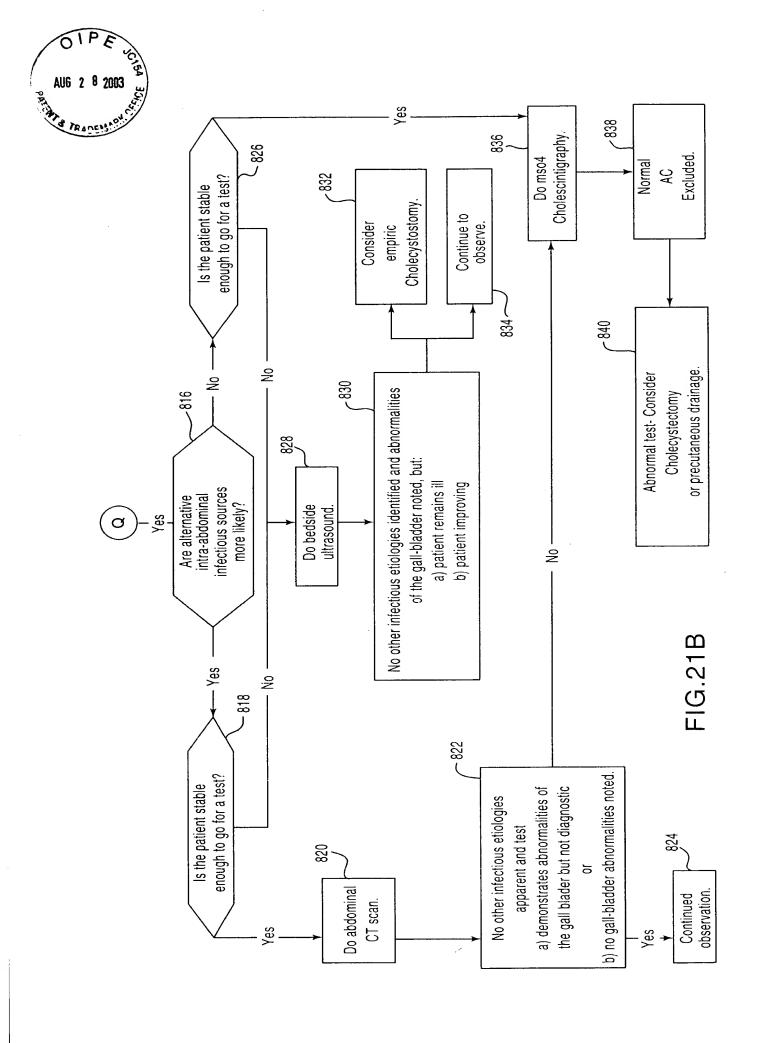
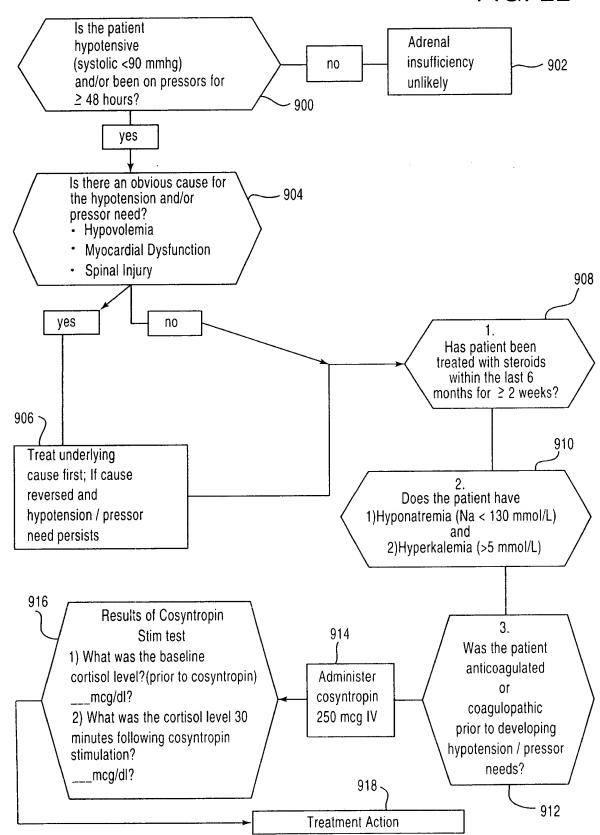
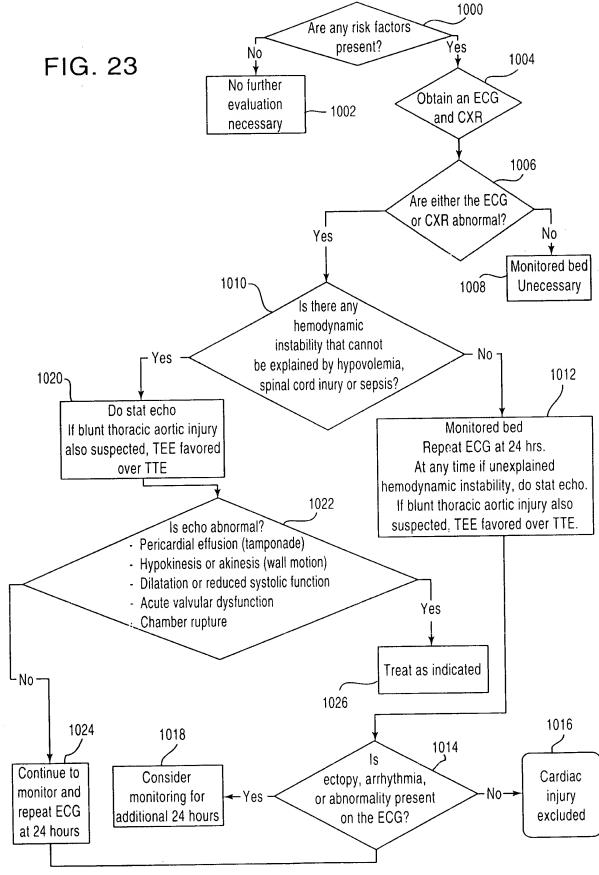




FIG. 22









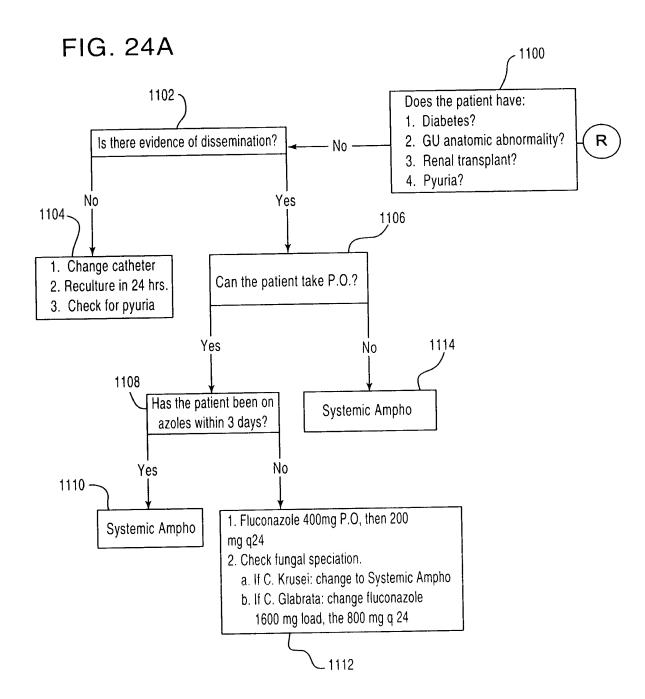
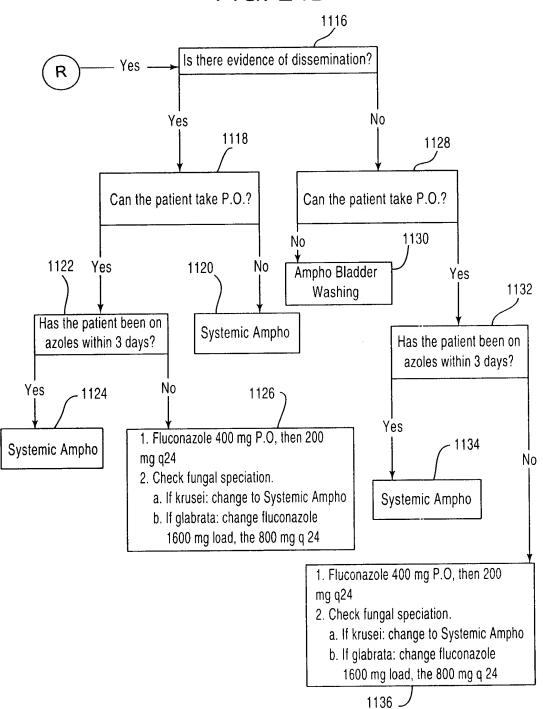
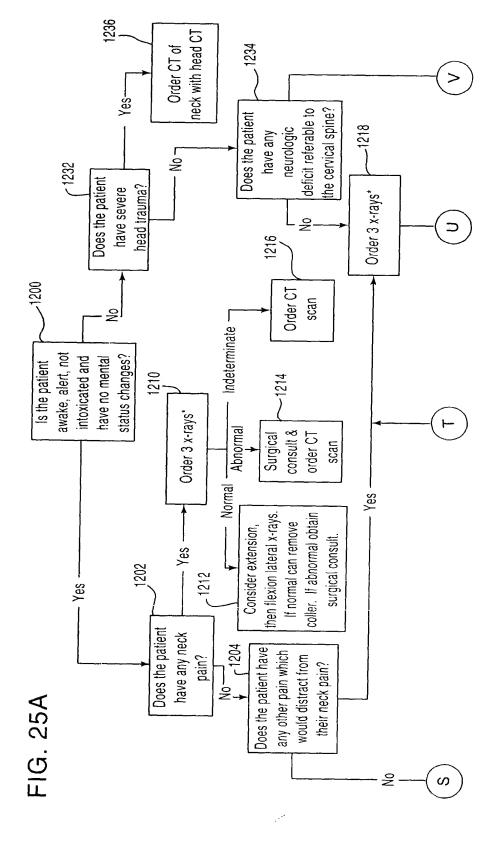




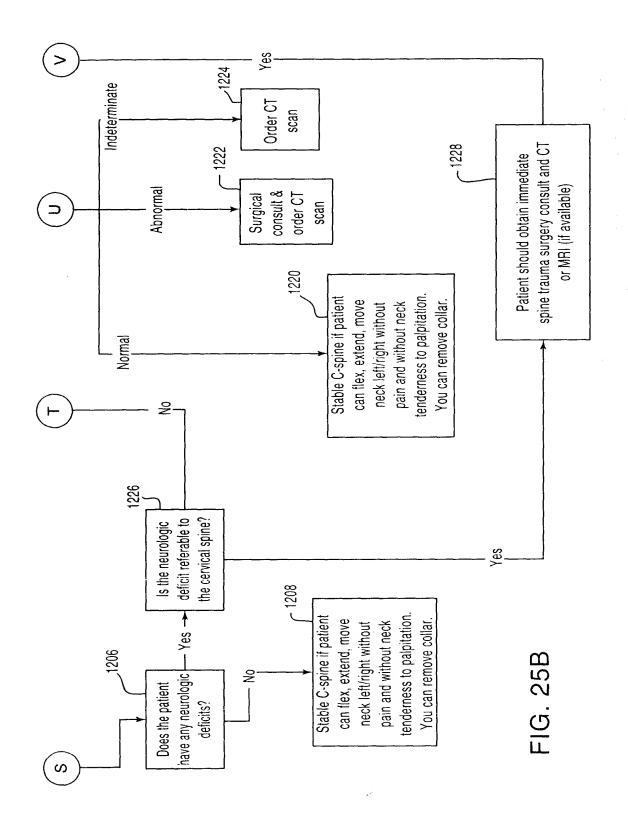
FIG. 24B



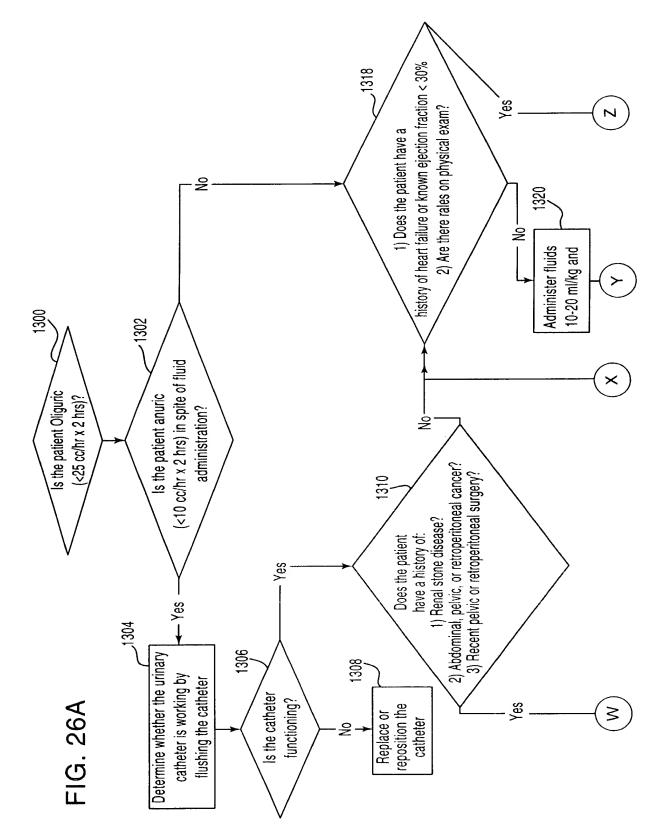














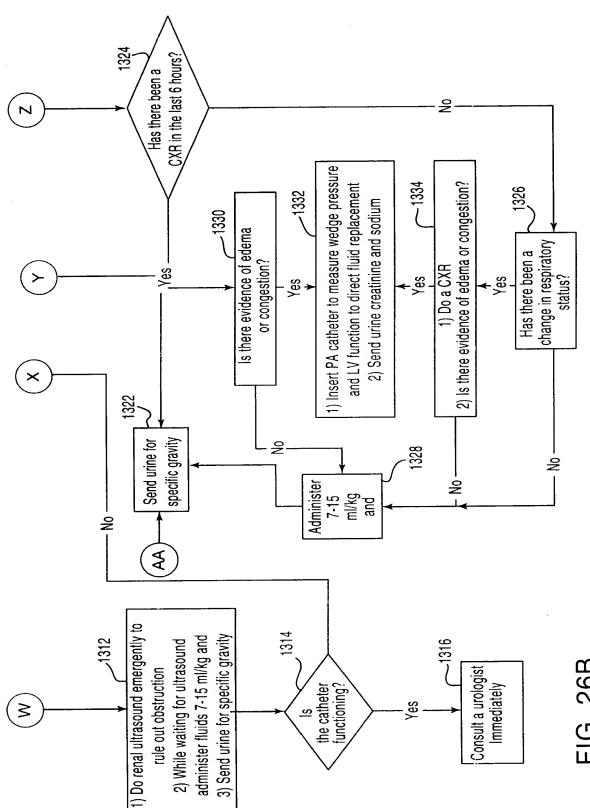
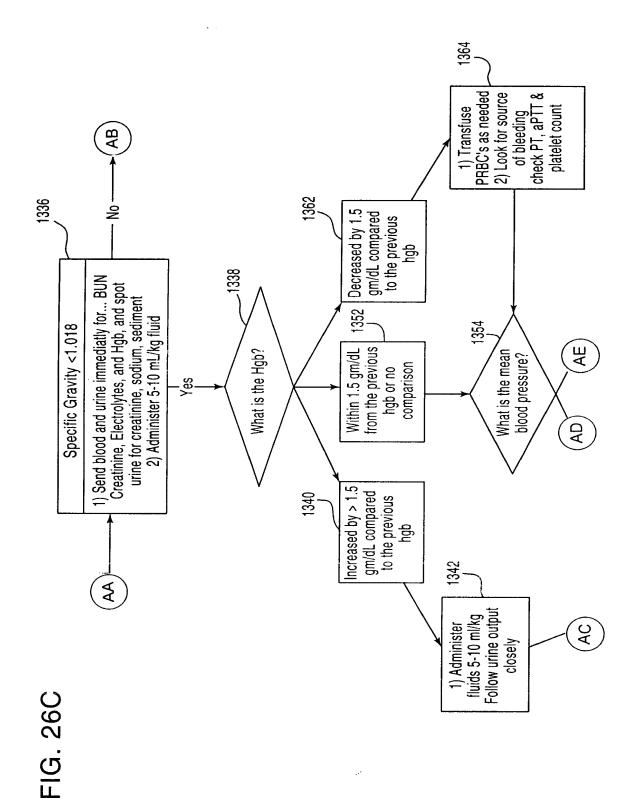
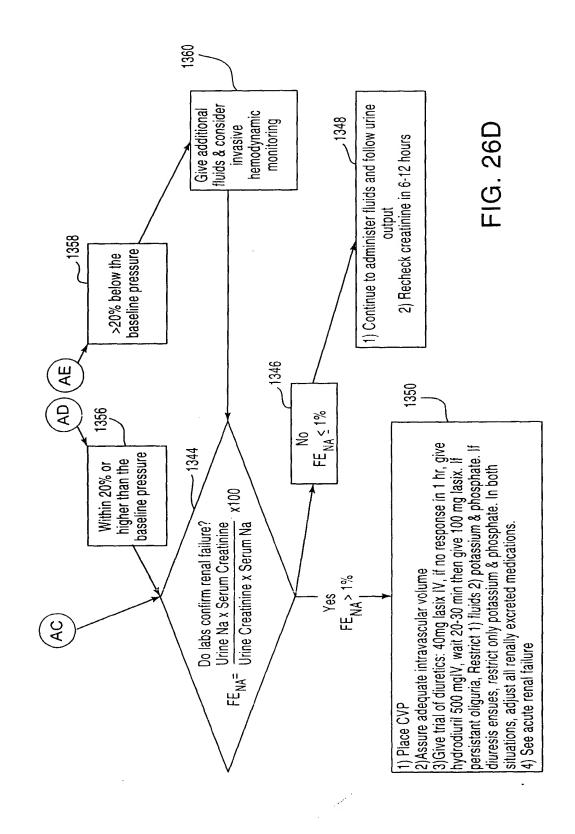


FIG. 26B

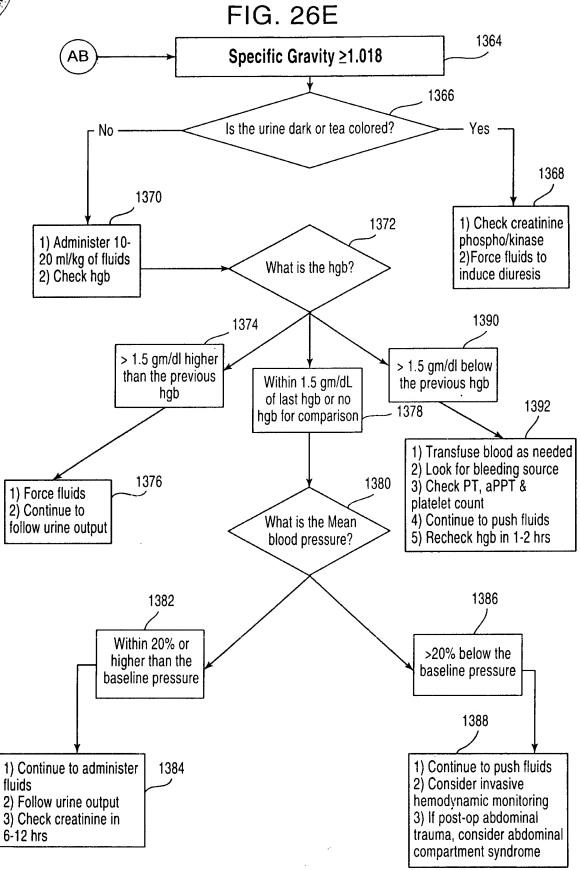




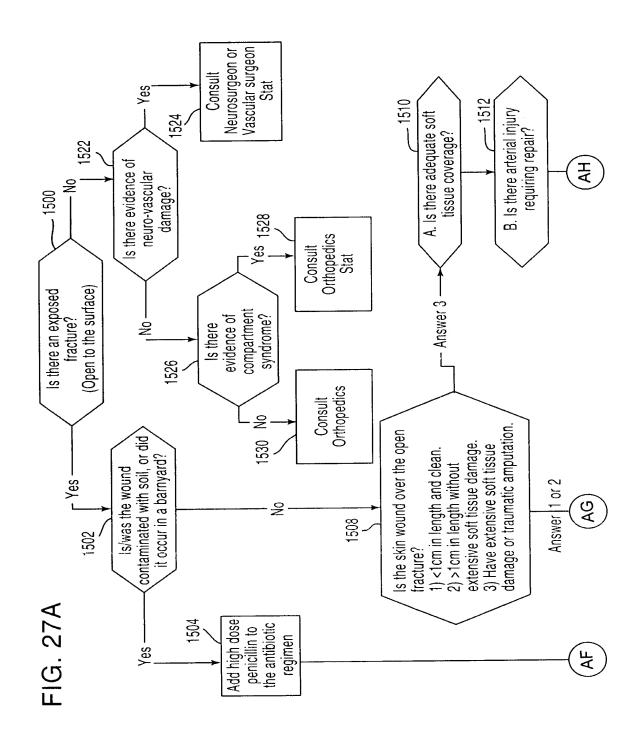




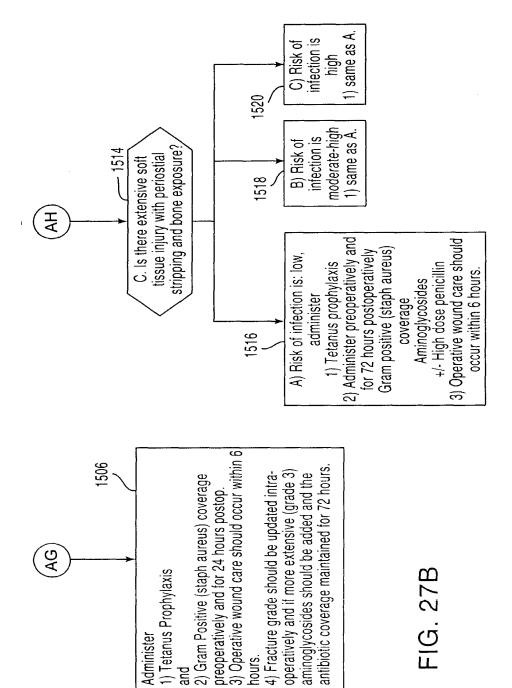












1) Tetanus Prophylaxis

Administer

AF

FIG. 27B

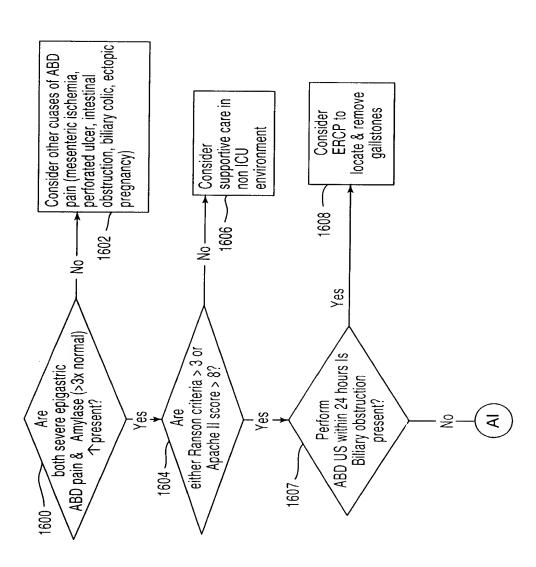
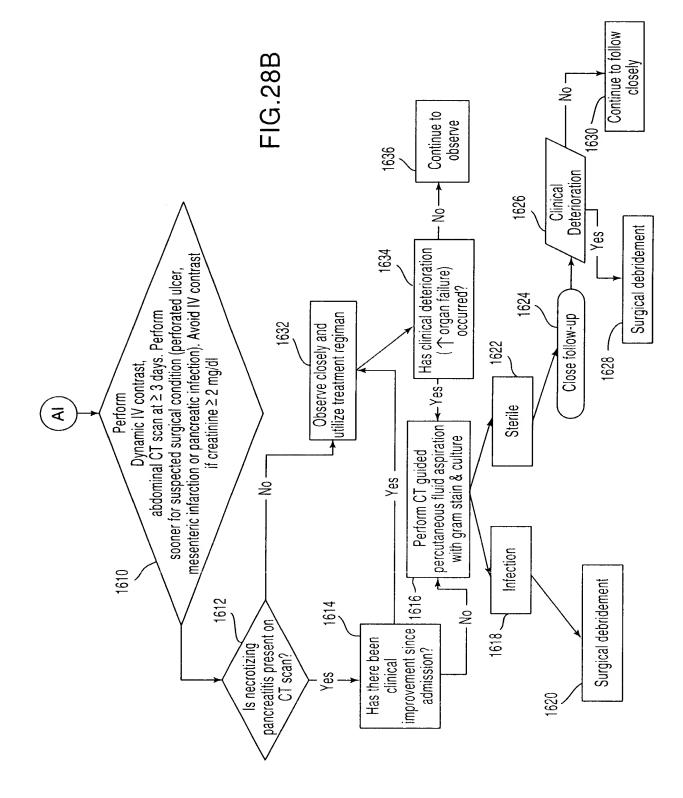


FIG. 28A







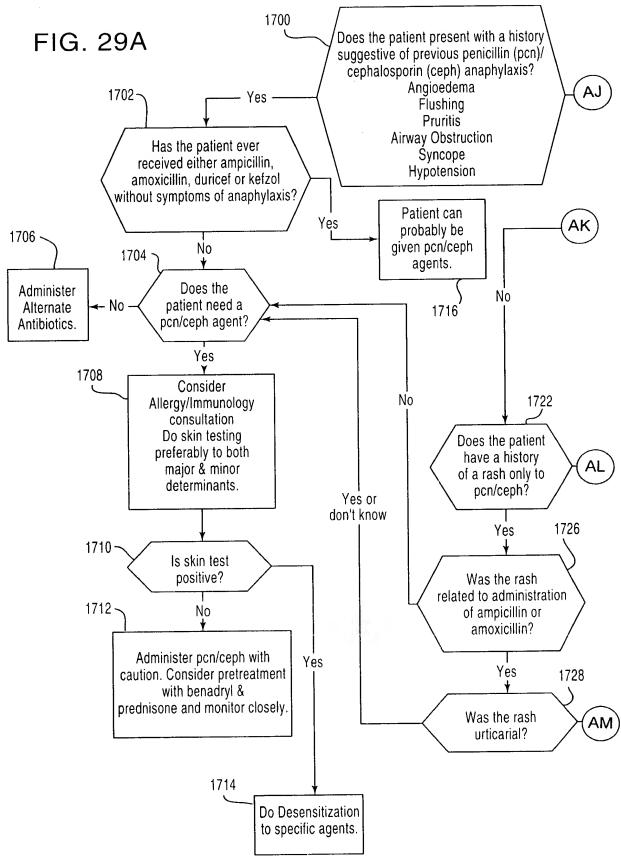
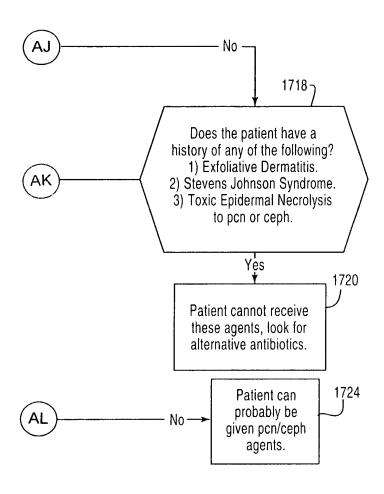




FIG.29B



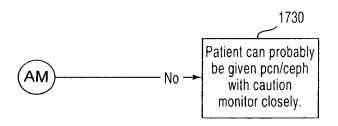
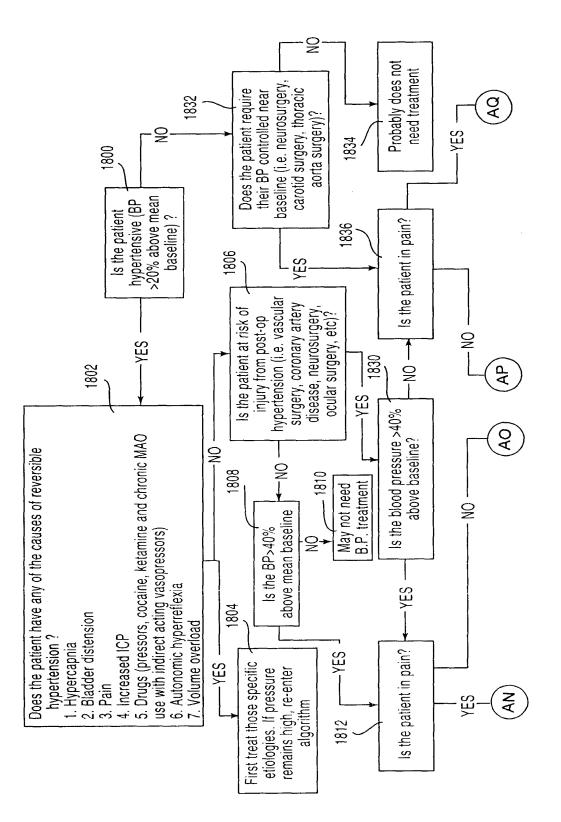




FIG. 30A





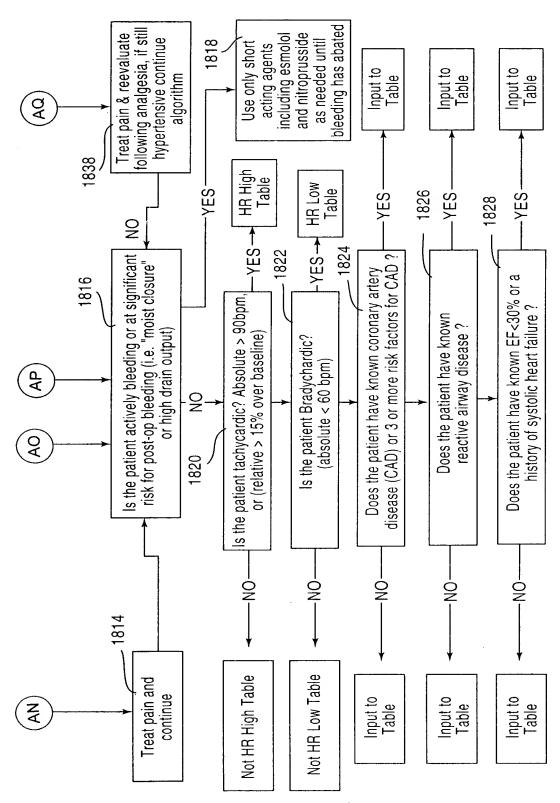
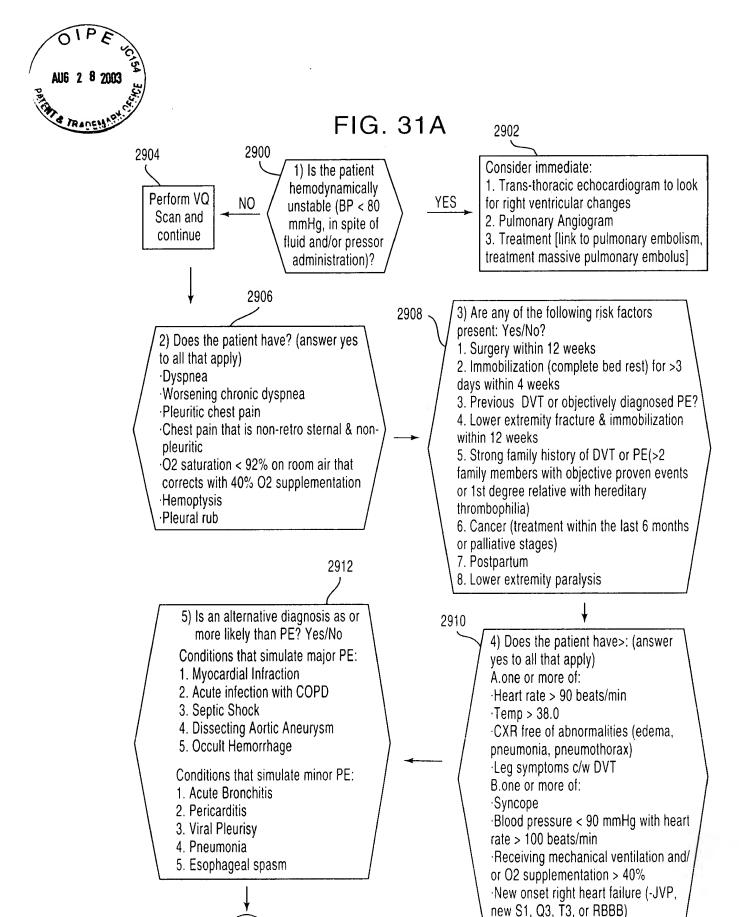
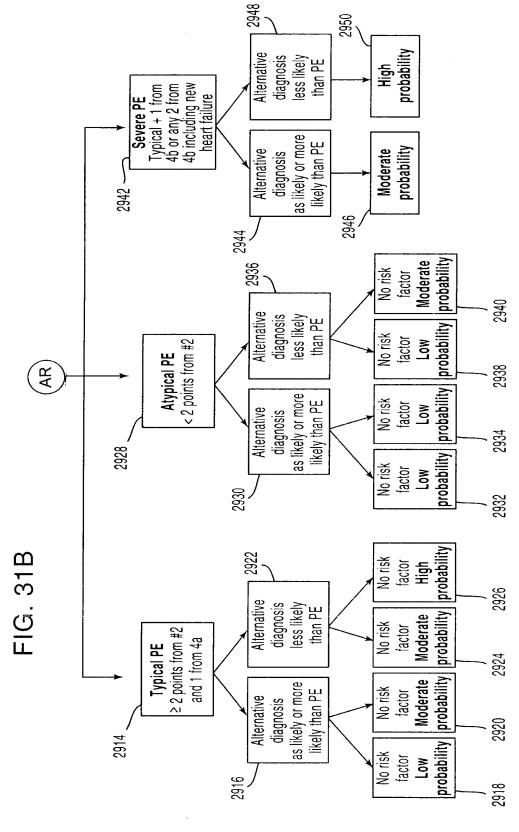


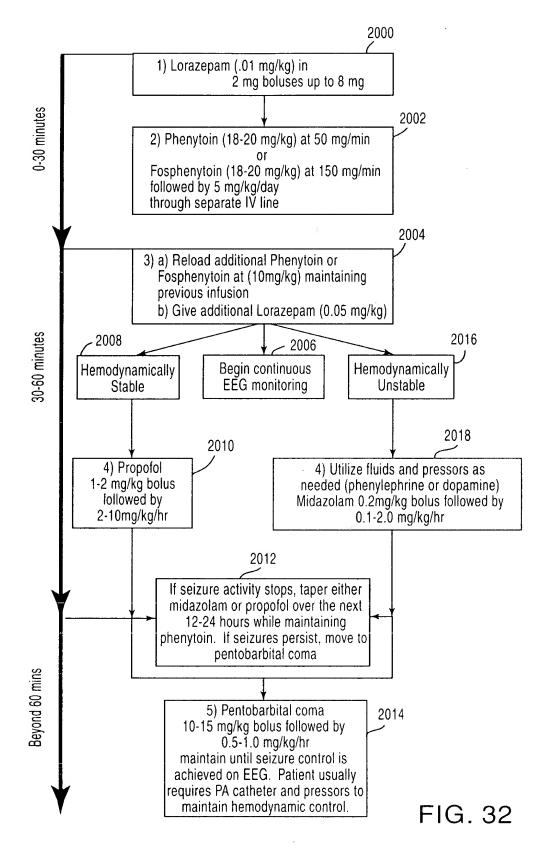
FIG.30B



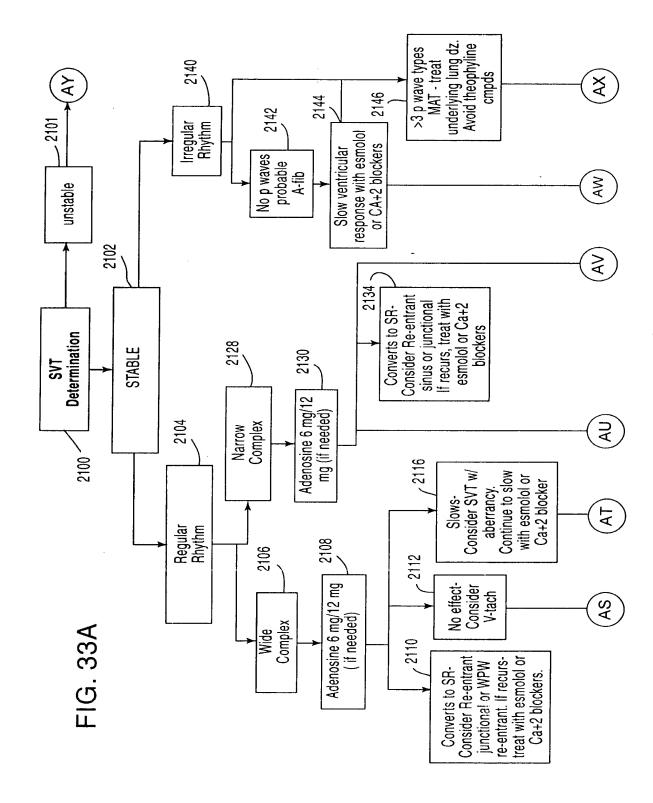














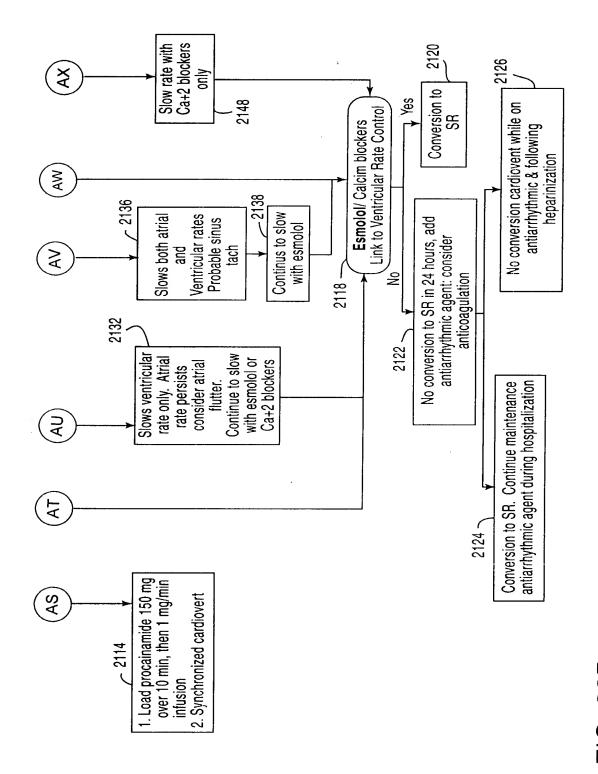
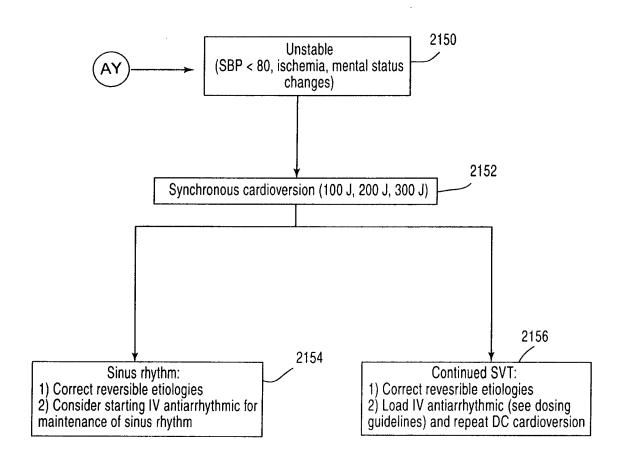


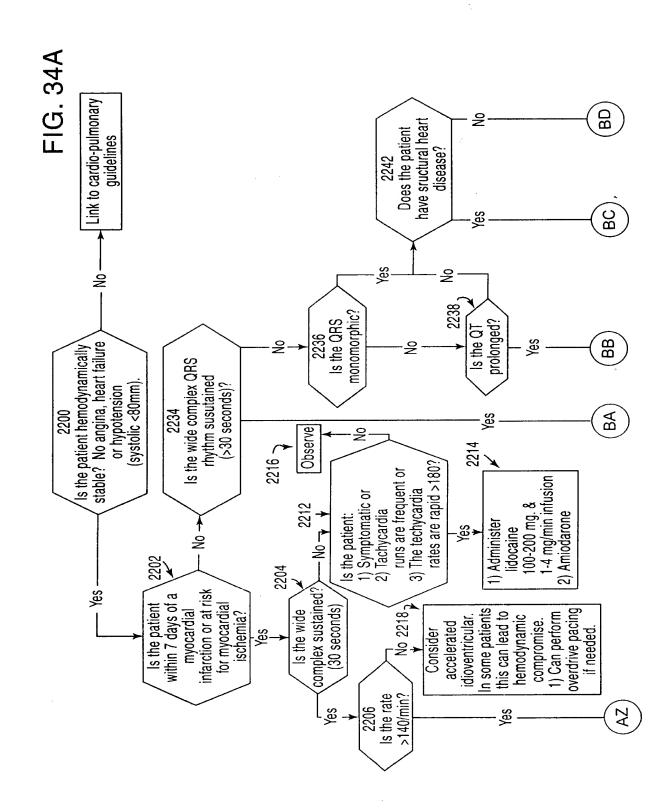
FIG. 33B



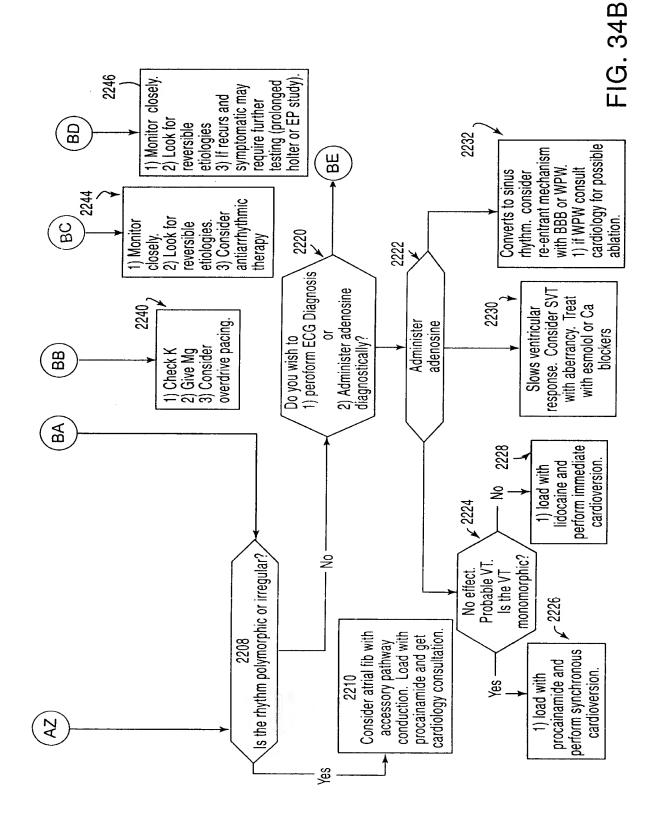
FIG. 33C



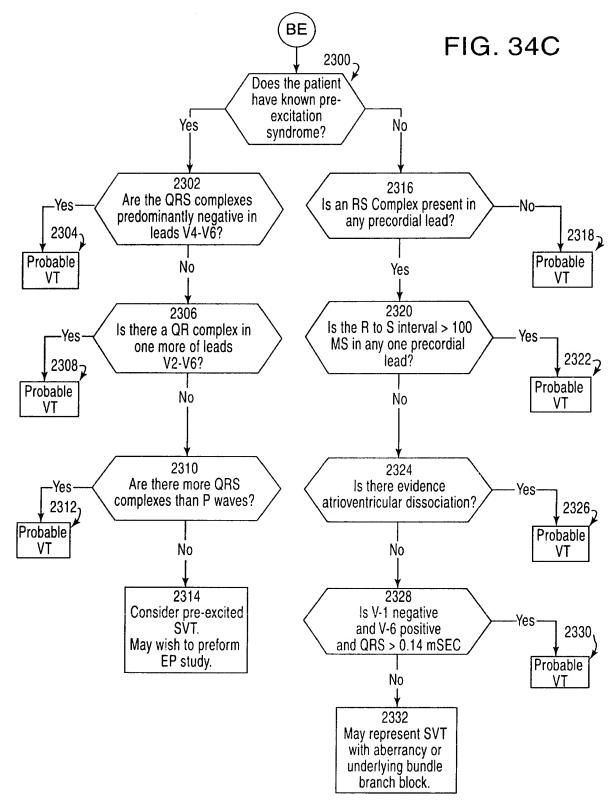




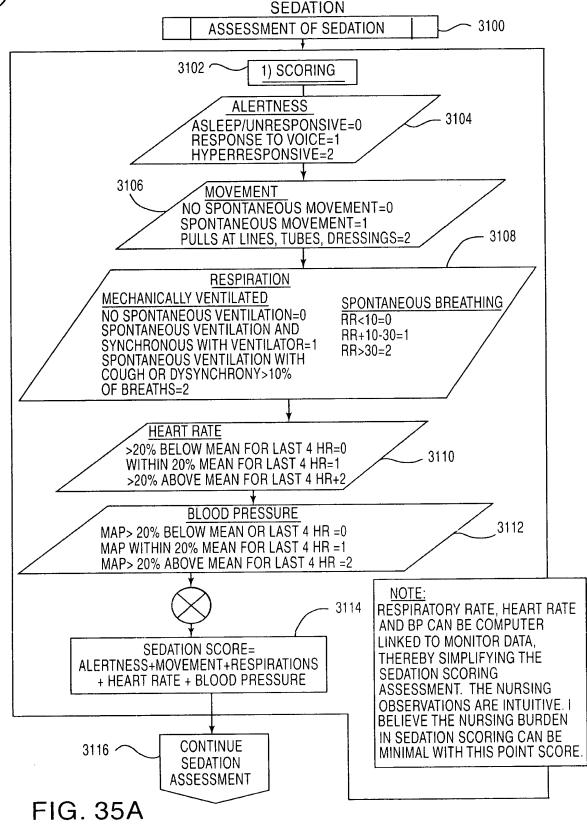














SEDATION ASSESSMENT CONTINUED

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2. PAIN ASSESSMENT

IS PATIENT CONSCIOUS, COMMUNICATIVE, AND ACKNOWLEDGING PAIN?

IF NOT, IS THE SEDATION SCORE > 2 AND THE PATIENT: KNOWN TO BE IN PAIN BEFORE BECOMING UNCOMMUNICATIVE

OR

S/P RECENT SURGERY

OR

HAVING TISSUE ISCHEMIA OR INFARCT

OR

S/P RECENT FRACTURE

OR

HAS WOUNDS

OR

HAS LARGE TUMOR POSSIBLY IMPINGING ON NERVES?

IF YES TREAT FOR PAIN.

3120

3. DELIRIUM ASSESSMENT

IS SEDATION SCORE > 2 AND PATIENT HAS:
DAY/NIGHT REVERSAL WITH INCREASED AGITATION AT NIGHT
OR

EYES OPEN AND "AWAKE" BUT DISORIENTED OR

EYES OPEN AND "AWAKE" BUT PULLING AT LINES, TUBES, OR DRESSINGS.

OR DIOD TO VE

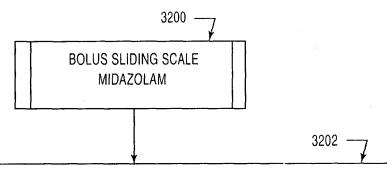
DIFFICULT TO SEDATE PRIOR TO VENTILATOR WEANING OR

PARADOXICAL RESPONSE TO BENZODIAZEPINES?

IF YES, CONSIDER BUTYROPHENONE.

FIG. 35B





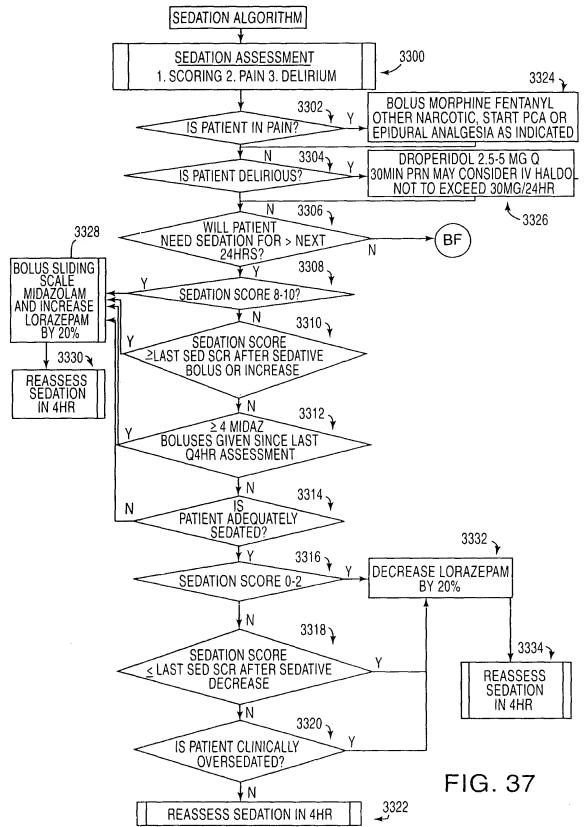
IF LORAZEPAM <0-2 MG IV Q 6HR THEN GIVE MIDAZOLAM 1-2 MG Q 5 MIN UNTIL ADEQUATELY SEDATED.

IF LORAZEPAM = 2-4 MG IV Q 4HR THEN GIVE MIDAZOLAM 2 MG Q 5 MIN UNTIL ADEQUATELY SEDATED.

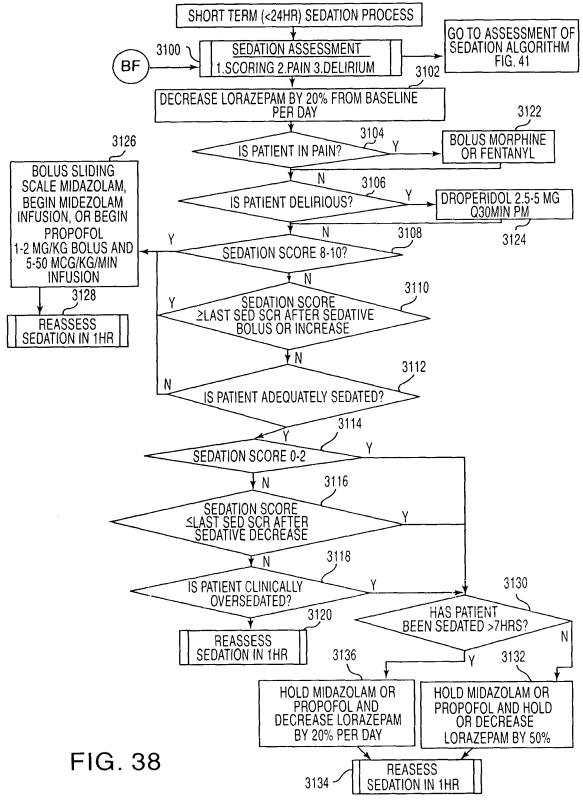
IF LORAZEPAM = 5-10 MG IV Q 4HR THEN GIVE MIDAZOLAM 2-5 MG Q 5 MIN UNTIL ADEQUATELY SEDATED.

IF LORAZEPAM >10MG IV Q 4HR THEN GIVE MIDAZOLAM 5 MG Q 5 MIN UNTIL ADEQUATELY SEDATED AND CONSIDER FENTANYL AND/OR DROPERIDOL OR HALDOL FOR SYNERGY DESPITE DELIRIUM AND PAIN ASSESSMENT.

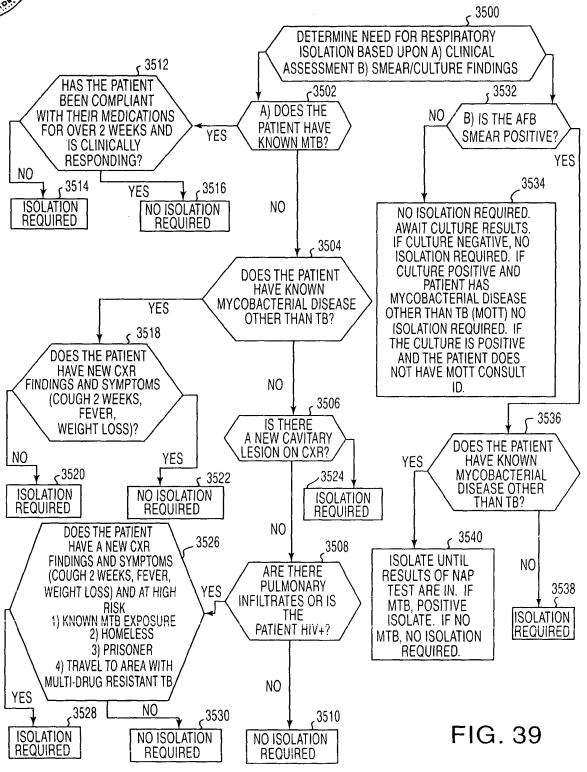














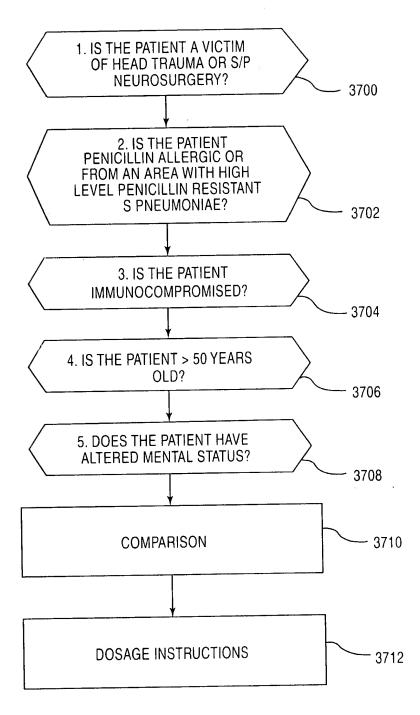
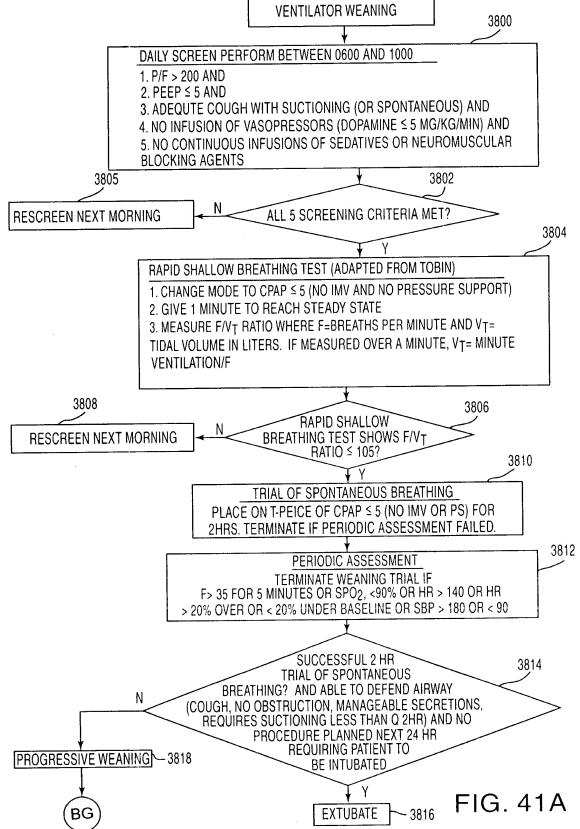


FIG. 40







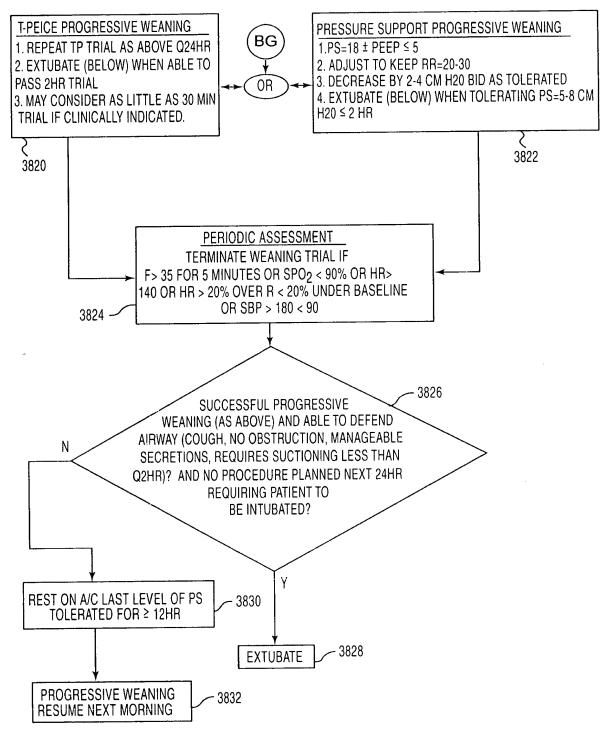


FIG. 41B



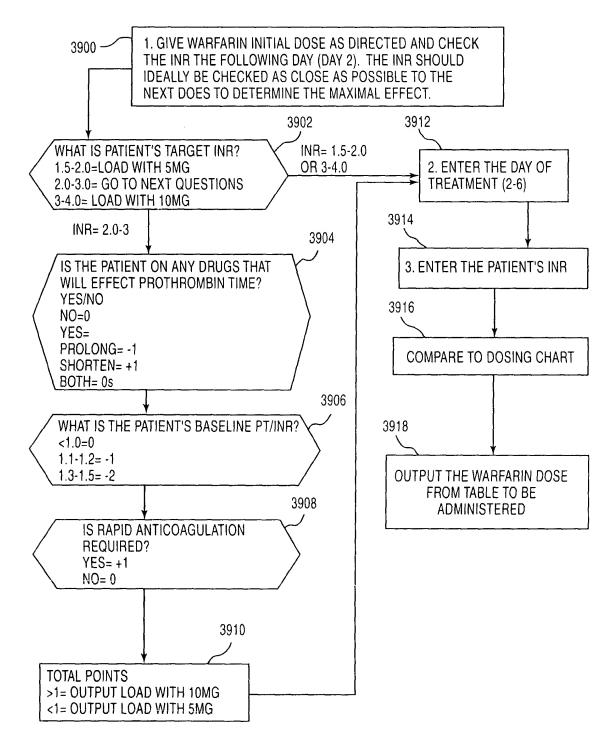


FIG. 42



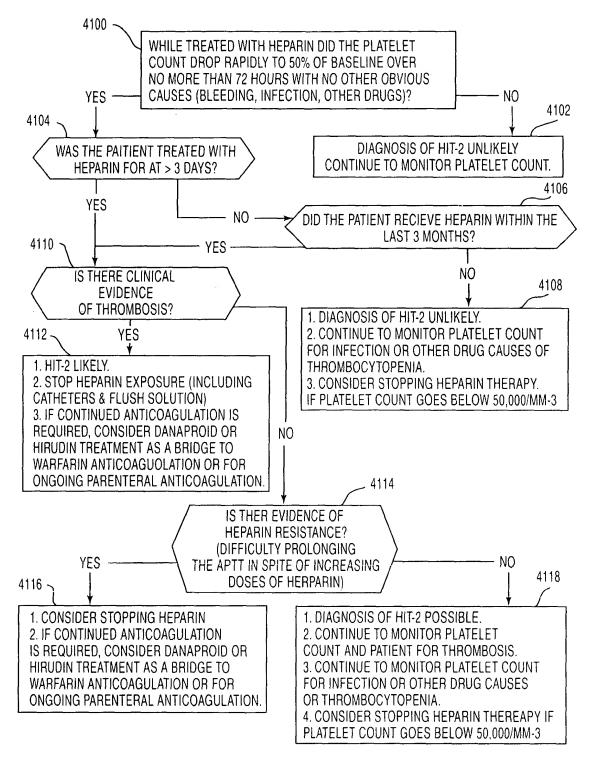


FIG. 43